

prior to lung cancer diagnosis, without a valid indication in a fifth of cases. Patients with an ICS more often experienced oral candidiasis.

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Optimizing the patient consent processes in community pharmacy services research: a mixed-methods study.

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Background: In pharmacy health services, effectively obtaining informed consent to collect patient health related data remains a cornerstone for patient-centred care and research participation. Despite growing interest in leveraging these services for accessible healthcare, providers often encounter barriers when collecting consent which limits participation and achieved outcomes. This study investigates patient perceptions and preferences of consent processes within primary care pharmacy contexts, thus providing insights into consent process enhancement to improve patient engagement.

Purpose: The objectives of this research are to (1) examine patients' experiences and perceptions of consent in a community pharmacy setting, (2) identify factors affecting the acceptability of consent processes, (3) develop alternative consent form prototypes, and (4) propose an optimised patient-centred consent model.

Methods: A bi-phasic mixed-methods approach integrating qualitative interviews and patient focus groups was utilised. In Phase One, semi-structured interviews with patient as partners were conducted to examine patient experiences, perceptions and preferences regarding the collection of study consent. Qualitative data was analysed deductively in accordance with the behaviour change framework COM-B model to identify factors affecting the acceptability of consent. In Phase Two, alternative consent form prototypes were developed based on Phase One findings. Prototypes have then been evaluated quantitatively using 6-point Likert scale and discussed in a patient focus groups including community-based patients, patient stakeholders and patient partners.

Findings: Five patient partners were interviewed during Phase One. Analysis is still ongoing, however, thus far, 13 factors have been mapped in accordance with the COM-B framework. *Psychological capability* (patient health literacy, research literacy, patient understanding of consent forms, patient perceptions towards health data sharing), *physical capability* (technological barriers, age-related factors influencing patient uptake of study participation), *reflective motivation* (incentives for participation, pharmacist's role in recruitment), *automatic motivation* (patients' attitudes and emotions towards signing a consent form), *physical opportunity* (written support, time and space for decision-making), *social opportunity* (social pressure to accept, social connection between patient and pharmacist). Guided by these insights, alternative consent form prototypes were co-created, incorporating various formats: a long-form, a short-form (with and without image support), an electronic consent form with e-signature, and an audio-visual presentation of information to improve understanding of the importance of data collection.

Conclusion: Findings are anticipated to significantly contribute to refining patient consent processes in pharmacy research toward a more accessible, patient-preferred consent model, potentially leading to higher research participation rates.

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Evaluation of an adapted New Medicine Service for the Swiss setting (myCare Start-I project) –a Hybrid Type II (cost)-effectiveness-implementation study protocol

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Background: In Switzerland, nearly half the population suffers from at least one long-term disease. Medication non-adherence worsens outcomes, and increases hospitalizations, mortality, and healthcare costs. While the UK's New Medicine Service (NMS) improved adherence by 10%, yet implementation in other countries has largely failed. The myCare Start Implementation Project (myCare Start-I) adapts NMS to Switzerland using implementation science. In Phase A, the NMS was adapted to the Swiss context and an implementation strategy package was developed through a contextual analysis using an iterative co-creation process with stakeholders.

Purpose: To evaluate the myCare Start service in Switzerland in view of effectiveness outcomes

i.e. medication adherence (primary outcome); cost-effectiveness, and implementation outcomes i.e. acceptability, adoption, appropriateness, fidelity, feasibility, reach and implementation cost.

Methods: We will use a Hybrid Type II effectiveness-implementation study design. The contextually adapted and interprofessional myCare Start service will be rolled-out in 30-40 early adopter pharmacies in the French- and German-speaking regions of Switzerland using a stepped wedge cluster randomized design. Adults with a prescription for a new long-term medicine will be eligible for inclusion. Medication initiation adherence will be assessed over 12 months using health insurance data and patient self-reports collected via the BAASIS® questionnaire at 6 weeks, and at 3, 6, and 12 months following the myCare Start service. Total healthcare costs and costs per quality-adjusted life years (QALY) will be estimated using health insurance data and patient reported quality of life (EQ-5D-5L). Markov modelling will be used to extrapolate results beyond trial follow-up. Implementation outcomes will be assessed from patient, pharmacist and physician perspective by a mix of quantitative surveys and qualitative interviews using validated tools and investigator-developed questions. Implementation costs (e.g. training, promotion, facilitation) will be calculated with the time-driven activity-based costing (TDABC) tool.

Findings: The trial is expected to begin in April 2025 and will last for 12 to 18 months. We hypothesise that patients receiving the myCare Start service will have higher rates of medication adherence, thereby translating into reduced overall healthcare utilisation and costs.

Conclusion: Evaluating the (cost)-effectiveness and implementation of the contextually adapted interprofessional myCare Start service will clarify its economic and therapeutic benefits for medication adherence at initiation as well as the implementation pathway in the Swiss primary care setting. A cost-effective and successfully implemented myCare Start service will provide the basis for further scale-up in the future.

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